

On May 14, 2001 appellant, then a 60-year-old mechanical engineer, filed an occupational disease claim for bilateral hearing loss sustained due to noise exposure in the performance of duty from 1967 to 2000. The Office referred appellant to Dr. Sage K. Copeland, a Board-certified otolaryngologist, for an evaluation of his hearing loss. Dr. Copeland submitted a November 21, 2001 audiogram showing the following thresholds at 500, 1,000, 2,000 and 3,000 hertz: on the left, 25, 30, 30 and 50 decibels; on the right, 30, 20, 30 and 60 decibels.

Dr. Copeland diagnosed severe bilateral high frequency neurosensory hearing loss causally related to occupational noise exposure. He recommended hearing protection and a hearing aid evaluation.

The Office referred Dr. Copeland's report to an Office medical adviser to determine if appellant's hearing loss was ratable under the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). In a January 23, 2002 report, an Office medical adviser reviewed Dr. Copeland's findings. For the right ear, the Office medical adviser added the frequency losses of 30, 20, 30 and 60 decibels to total 140 decibels. He then divided the total of 140 by 4, resulting in 35 decibels. The adviser then subtracted the "fence" of 25 decibels, to equal 10. When multiplied by the 1.5 monaural loss factor, this equaled a 15 percent monaural loss of hearing in the right ear. For the left ear, the Office medical adviser totaled the 25, 30, 30 and 50 decibel losses to equal 135 decibels. He then divided the total of 135 by 4, to equal 33.75 decibels. The adviser then subtracted the "fence" of 25 decibels, to equal 8.75. When multiplied by the 1.5 monaural loss factor, this equaled a 13.13 percent monaural loss of hearing in the left ear, rounded down to 13 percent. The Office medical adviser then multiplied the lesser loss by 5 to equal 65.65, added the greater loss of 15 to equal 80.65, and divided the total by 6 resulting in a 13.44 or a 13 percent binaural loss of hearing.

By decision dated August 28, 2002, the Office issued appellant a schedule award for a 13 percent binaural hearing loss. Appellant disagreed and requested an oral hearing, held April 2, 2003. He asserted that he was entitled to an additional schedule award for bilateral tinnitus interfering with hearing and sleeping. After the hearing, appellant submitted an April 15, 2003 report by Jan C. Liles, a doctor of audiology, who opined that the A.M.A., *Guides'* impairment calculation did not reflect appellant's inability to hear high frequency consonants "responsible for speech understanding or clarity." Dr. Liles stated that binaural amplification using digital aids designed for high frequency hearing loss would "likely provide significant benefit" for appellant.

By decision dated and finalized June 19, 2003, the Office hearing representative affirmed the August 28, 2002 schedule award, finding that there was no medical evidence supporting an increased percentage of impairment or regarding the impact of tinnitus on appellant's ability to hear. The hearing representative directed the Office to "address the recommended hearing amplification."

### **LEGAL PRECEDENT**

The Office evaluates industrial hearing loss in accordance with the standards contained in the A.M.A., *Guides*.<sup>1</sup> Using the frequencies of 500, 1,000, 2,000 and 3,000 hertz or cycles per second, the losses at each frequency are added up and averaged.<sup>2</sup> Then, the "fence" of 25 decibels is deducted since, as the A.M.A., *Guides* points out, losses below 25 decibels result in no impairment in the ability to hear everyday speech in everyday conditions.<sup>3</sup> The remaining amount

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<sup>1</sup> A.M.A., *Guides* (5<sup>th</sup> ed. 2001) at 250.

<sup>2</sup> *Id.*

<sup>3</sup> *Id.*

is multiplied by 1.5 to arrive at the percentage of monaural hearing loss.<sup>4</sup> The binaural loss is determined by calculating the loss in each ear using the formula for monaural loss; the lesser loss is multiplied by five, then added to the greater loss and the total is divided by six to arrive at the amount of the binaural hearing loss.<sup>5</sup> The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.<sup>6</sup>

### ANALYSIS

The Office medical adviser applied the Office's standardized procedures to the November 21, 2001 audiogram performed for Dr. Copeland. Testing for the right ear at the frequency levels of 500, 1,000, 2,000 and 3,000 hertz revealed decibel losses of 30, 20, 30 and 60. These decibels were totaled at 140 decibels and were divided by 4 to obtain the average hearing loss at those cycles of 35 decibels. The average of 35 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 10, which was multiplied by the established factor of 1.5 to compute a 15 percent loss of hearing for the right ear. Testing for the left ear at the frequency levels of 500, 1,000, 2,000 and 3,000 hertz revealed decibel losses of 25, 30, 30 and 50. These decibels were totaled at 135 decibels and were divided by 4 to obtain the average hearing loss at those cycles of 33.75 decibels. The average of 33.75 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 8.75, which was multiplied by the established factor of 1.5 to compute a 13.13 percent loss of hearing for the left ear, rounded down to 13 percent. The Office medical adviser then multiplied the lesser loss by 5 to equal 65.65, added the greater loss of 15 to equal 80.65, and divided the total by six, resulting in a 13.44 percent binaural loss of hearing, rounded down to 13 percent. Accordingly, pursuant to the Office's standardized procedures, the Office medical adviser determined that appellant had a 13 percent binaural hearing loss.

Appellant did not allege that the Office erred in its calculations. Rather, he asserts entitlement to an additional schedule award for tinnitus. The A.M.A., *Guides* states that "tinnitus in the presence of unilateral or bilateral hearing impairment may impair speech discrimination. Therefore, up to five percent for tinnitus in the presence of measurable hearing loss may be added if the tinnitus impacts the ability to perform activities of daily living." However, appellant has not submitted medical evidence diagnosing tinnitus.

The Board notes that Dr. Liles, a doctor of audiology, opined that the 13 percent impairment rating did not encompass appellant's inability to understand speech. However, as an audiologist is not included among the list of healthcare professionals recognized as a "physician" under 5 U.S.C. § 8101(2), Dr. Liles' opinion cannot constitute probative medical evidence on the schedule award issue.<sup>7</sup>

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<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> *Donald E. Stockstad*, 53 ECAB \_\_\_\_ (Docket No. 01-1570, issued January 23, 2002), *petition for recon. granted (modifying prior decision)*, Docket No. 01-1570 (issued August 13, 2002).

<sup>7</sup> *Leon Thomas*, 52 ECAB 202 (2001).

**CONCLUSION**

The Board finds that appellant has not established that he sustained greater than a 13 percent binaural hearing loss, as he did not submit medical evidence demonstrating an increased percentage of impairment.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated and finalized June 19, 2003 is affirmed.

Issued: February 17, 2004  
Washington, DC

Colleen Duffy Kiko  
Member

David S. Gerson  
Alternate Member

A. Peter Kanjorski  
Alternate Member